

For Doctor Use Only		
APPT _____	WI _____	
N/P _____	P/P _____	
DR _____		
VISIT CL _____	GL'S _____	OTHER _____

DATE \_\_\_\_\_

Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Hm. Phone \_\_\_\_\_ Wk. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Referred by \_\_\_\_\_

Are you a new patient? Yes  No

Date of last vision exam \_\_\_\_\_ Doctor \_\_\_\_\_

Are you pregnant at this time? Yes  No

List any health problems \_\_\_\_\_

Or history of any tobacco, alcohol or substance abuse \_\_\_\_\_

Are you taking any medications and for what? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

Does anyone in your immediate family have glaucoma, cataracts, diabetes, hypertension, or any other disease? If so, what and whom? \_\_\_\_\_

Do you use cigarettes/tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Other substance? \_\_\_\_\_

**DO YOU EVER EXPERIENCE THE FOLLOWING EYE HEALTH SYMPTOMS?**

- |   |                                    |   |                                    |
|---|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Dryness of eyes  | <input type="checkbox"/> Burning   | <input type="checkbox"/> Decreased vision   | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Mucous discharge | <input type="checkbox"/> Watering  | <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Floaters  |
| <input type="checkbox"/> Redness          | <input type="checkbox"/> Lights    | <input type="checkbox"/> Loss of vision     | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Gritty feeling   | <input type="checkbox"/> Eye pain  | <input type="checkbox"/> Tired eyes         | <input type="checkbox"/> Lazy eye  |
| <input type="checkbox"/> Itching          | <input type="checkbox"/> Infection | <input type="checkbox"/> Flashes of light   | <input type="checkbox"/> Glare     |
| <input type="checkbox"/> Other? _____     |                                    |   |                                    |

Are you interested in Laser Vision Correction?  Yes /  No

Are you interested in glasses?  Yes /  No

Are you interested in Contacts?  Yes /  No

***Person responsible for Professional Fees:***

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

***Accounts are expected to be paid when services are rendered.***

- Cash  Check  Visa  Master Card  American Express  Discover  
 Vision Insurance \_\_\_\_\_  Medical Insurance \_\_\_\_\_  
 Medicare# \_\_\_\_\_  Medicaid# \_\_\_\_\_  DHS# \_\_\_\_\_

## VISUAL FIELDS AND DILATION

Dr. Robert H. Zoellner strongly recommends that all of our patients receive a visual field test and a dilation as part of our comprehensive visual analysis.

A highly sophisticated computerized instrument now enables us to provide a more thorough visual field screening. This instrument checks for loss of sight, both in central and peripheral areas. Visual field testing can assist us in early detection of glaucoma, retinal problems, some neurological diseases (such as brain tumors and optic nerve disease), and better enables us to diagnose causes of headaches. The fee is \$15.00.

While routine dilation of the eyes is recommended at least every two years, if you have a condition such as diabetes, cataracts, high blood pressure, headaches, high nearsightedness, symptoms of flashing lights or floaters, glaucoma or a family history of glaucoma, you are urged to have your pupils dilated today. Dilation involves placing drops in your eyes to enlarge the pupil size.

When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids us in determining diseases (such as macular degeneration, glaucoma and tumors), damage to the retina (such as holes or tears) and evaluation of cataracts.

With dilation of the eyes you may experience the following effects:

- 1) increased sensitivity to light
- 2) a slight blurring of distance vision
- 3) inability to focus up close

These effects last from 2-4 hours. The fee for this test is \$15.00

**Please Note:**

- Visual fields show us how the retina functions.
- A dilation, allows us a view of the back of the eye.
- Both are equally important.

**Please check one of the following and sign below:**

\_\_\_\_\_ I do consent to having both visual fields and a dilation. The fee for both is reduced from \$30.00 to \$25.00.

\_\_\_\_\_ I do consent to only the visual fields for \$15.00.

\_\_\_\_\_ I do consent to only the dilation for \$15.00.

\_\_\_\_\_ I do understand the importance of visual field testing and a dilation, yet I do not wish to have either performed at this time. I release Dr. Robert Zoellner from any liabilities related to the failure to treat or diagnose any eye conditions due to the lack of diagnostic information which could have been obtained by these test.

\_\_\_\_\_  
(Patient's Signature or Guardian)

\_\_\_\_\_  
Date

WE WILL NEED THE FOLLOWING  
INFORMATION IN ORDER TO FILE YOUR  
INSURANCE

PLEASE CIRCLE WHICH VISION COVERAGE  
YOU HAVE:

VISION SERVICE PLAN  
SPECTERA (UNITED HEALTHCARE, OPTUM)  
STATE (MEDICAID, SOONERCARE, ETC.)

PRIMARY MEMBER INFORMATION

PRIMARY MEMBER NAME: \_\_\_\_\_  
PRIMARY MEMBER DATE OF BIRTH: \_\_\_\_\_  
PRIMARY MEMBER SS#: \_\_\_\_\_  
PRIMARY MEMBER PHONE NUMBER: \_\_\_\_\_  
PRIMARY MEMBER EMPLOYER: \_\_\_\_\_  
PRIMARY MEMBER ADDRESS INCLUDING ZIP  
CODE: \_\_\_\_\_

PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_  
PATIENT DATE OF BIRTH: \_\_\_\_\_